MassHealth

Billing Instructions for Paper Claim Form No. 7

Executive Office of Health and Human Services
MassHealth
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BG-7-CL (02/08)

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Introduction

The following information describes in detail how to bill on the paper claim form no. 7. For administrative and billing instructions, see Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the Guide to Remittance Advice and Electronic Equivalents for Claim Form No. 7, available online at www.mass.gov/masshealth.

General Instructions for Submitting Paper Claims

Claim Form No. 7

All transportation providers may use claim form no. 7 (Request for Payment - Transportation Claim) when submitting paper claims to MassHealth.

Providers may request supplies of claim form no. 7 by submitting a request to the MassHealth address found in Appendix A of your MassHealth provider manual.

Entering Information on Claim Form No. 7

Follow these guidelines when filling out the claim form.

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information on the claim form (as stated in the instructions), using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as “same as above.”
- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, enter the date in MMDDYY format.

Time Limitations on the Submission of Claims

The period fixed by statute (M.G.L. c. 118E, §20) for the submission of claims is 90 days, measured from the date of service or the date on the explanation of benefits (EOB) to the date on which the claim form is received by MassHealth. For regulations governing time limitations on the submission of claims, see the billing regulations in Subchapter 3 of your MassHealth provider manual.

Since the 90-day requirement applies to each claim line, the claim form must be received within 90 days from the earliest date of service on the form.

All services listed on a single claim line must have been provided in the same fiscal year. That is, if you are allowed to submit consecutive dates of service on a single claim line (that is, “from and thru” billing), dates of service from the months of June and July should never appear on the same claim line.

General Instructions for Submitting Paper Claims (cont.)

Claims for Members with Other Health Insurance Coverage

Special instructions for submitting claims for services furnished to members with health insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

To submit electronic claims, contact MassHealth Customer Service. Refer to Appendix A of your MassHealth provider manual for contact information. Additional information is also available in Subchapter 5 of your provider manual.

Where to Send Paper Claim Forms

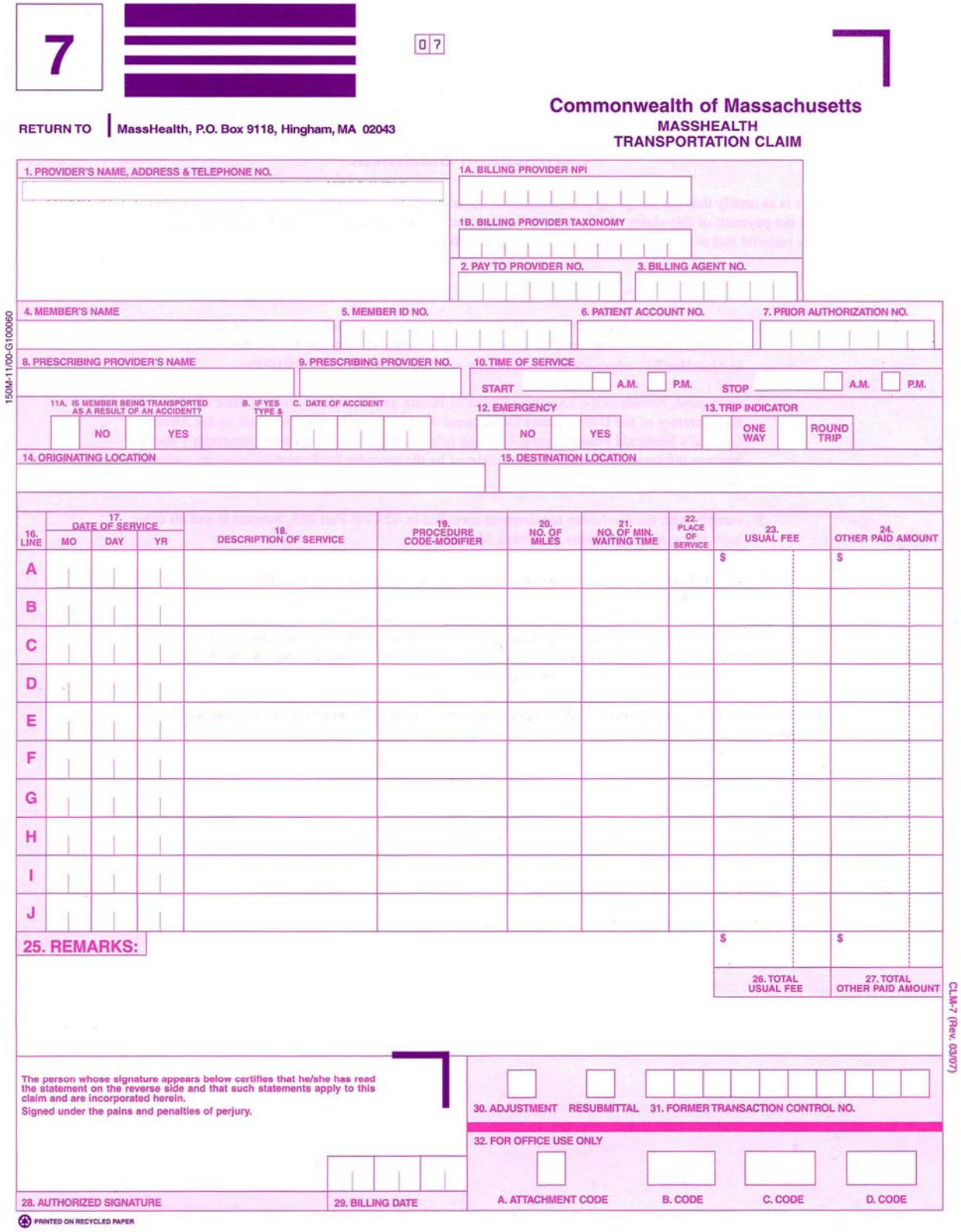
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following item-by-item instructions, you need additional assistance to complete claim form no. 7, contact MassHealth Customer Service. For additional information about submitting claims, consult the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual. Please refer to Appendix A of your provider manual for all MassHealth Customer Service contact information.

Item-by-Item Instructions for Claim Form No. 7

A sample claim form is shown below. Following this sample are completion instructions for each field on claim form no. 7.



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RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

Commonwealth of Massachusetts
MASSHEALTH
TRANSPORTATION CLAIM

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.

1A. BILLING PROVIDER NPI

1B. BILLING PROVIDER TAXONOMY

2. PAY TO PROVIDER NO.

3. BILLING AGENT NO.

4. MEMBER'S NAME

5. MEMBER ID NO.

6. PATIENT ACCOUNT NO.

7. PRIOR AUTHORIZATION NO.

150M-11/00-G100060

8. PRESCRIBING PROVIDER'S NAME

9. PRESCRIBING PROVIDER NO.

10. TIME OF SERVICE
START ☐ A.M. ☐ P.M. STOP ☐ A.M. ☐ P.M.

11A. IS MEMBER BEING TRANSPORTED AS A RESULT OF AN ACCIDENT? ☐ NO ☐ YES

B. IF YES TYPE &

C. DATE OF ACCIDENT

12. EMERGENCY ☐ NO ☐ YES

13. TRIP INDICATOR ☐ ONE WAY ☐ ROUND TRIP

14. ORIGINATING LOCATION

15. DESTINATION LOCATION

16. LINE	17. DATE OF SERVICE MO	DAY	YR	18. DESCRIPTION OF SERVICE	19. PROCEDURE CODE-MODIFIER	20. NO. OF MILES	21. NO. OF MIN. WAITING TIME	22. PLACE OF SERVICE	23. USUAL FEE	24. OTHER PAID AMOUNT
A									$	$
B										
C										
D										
E										
F										
G										
H										
I										
J										

25. REMARKS:

$ $

26. TOTAL USUAL FEE

27. TOTAL OTHER PAID AMOUNT

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The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

28. AUTHORIZED SIGNATURE

29. BILLING DATE

30. ADJUSTMENT ☐ RESUBMITTAL ☐ 31. FORMER TRANSACTION CONTROL NO.

32. FOR OFFICE USE ONLY

A. ATTACHMENT CODE B. CODE C. CODE D. CODE

PRINTED ON RECYCLED PAPER

Item-by-Item Instructions for Claim Form No. 7 (cont.)

Item No.	Item Name	Description
1	Provider's Name, Address & Telephone No.	Enter the provider's name, address, and telephone number.
1A	Billing Provider NPI	Enter your billing (pay-to) NPI.
1B	Billing Provider Taxonomy	Enter the taxonomy code applicable for the billing (pay-to) NPI only if instructed to do so by MassHealth.
2	Pay to Provider No.	Leave this item blank unless you are a non-emergency transportation provider and do not have an NPI.
3	Billing Agent No.	If this form is prepared by a billing agent, enter the seven-digit number assigned to the agent. If one was not assigned, leave this item blank.
4	Member's Name	Enter the name of the member receiving services.
5	Member's ID No.	Enter the complete 10-character member identification number that is printed on the MassHealth card below or beside the member's name. The member ID number on the temporary MassHealth card may include an asterisk as the 10th character.
6	Patient Account No.	Enter the patient account number, if one is assigned. If one is not assigned, enter the member's last name.
7	Prior Authorization No.	Enter the six-digit PA number assigned by MassHealth, if applicable.
8	Prescribing Provider's Name	Leave this item blank.
9	Prescribing Provider No.	Leave this item blank.

Item-by-Item Instructions for Claim Form No. 7 (cont.)

Item No.	Item Name	Description
10	Time of Service	Using the 24-hour time as indicated in the chart below, enter the time the ambulance trip began in the space for "Start" and the time it ended in the space for "Stop." Leave the A.M./P.M. boxes blank. *Round Trip*: Enter the time the return trip ended.
11A	Is member being transported as a result of an accident?	Check the appropriate box.
11B	If yes, type?	If 11A is yes, this item is required. Enter the code from the list below that describes the type of accident. 1– Automobile-related 2– Employment-related 3– Other
11C	Date of Accident	If 11A is yes, enter the date on which the accident occurred in MMDDYY format.

12-Hour Time	24-Hour Equivalent
12:01-12:59 A.M.	0001-0059
1:00-1:59 A.M.	0100-0159
2:00-2:59 A.M.	0200-0259
3:00-3:59 A.M.	0300-0359
4:00-4:59 A.M.	0400-0459
5:00-5:59 A.M.	0500-0559
6:00-6:59 A.M.	0600-0659
7:00-7:59 A.M.	0700-0759
8:00-8:59 A.M.	0800-0859
9:00-9:59 A.M.	0900-0959
10:00-10:59 A.M.	1000-1059
11:00-11:59 A.M.	1100-1159
12:00-12:59 P.M.	1200-1259
1:00-1:59 P.M.	1300-1359
2:00-2:59 P.M.	1400-1459
3:00-3:59 P.M.	1500-1559
4:00-4:59 P.M.	1600-1659
5:00-5:59 P.M.	1700-1759
6:00-6:59 P.M.	1800-1859
7:00-7:59 P.M.	1900-1959
8:00-8:59 P.M.	2000-2059
9:00-9:59 P.M.	2100-2159
10:00-10:59 P.M.	2200-2259
11:00-11:59 P.M.	2300-2359
Midnight P.M.	2400

Item-by-Item Instructions for Claim Form No. 7 (cont.)

Item No.	Item Name	Description
12	Emergency	Enter an "X" in the appropriate box to indicate if the service is an emergency.
13	Trip Indicator	*One Way:* Enter an "X" in the checkbox. *Round Trip:* Leave this item blank.
14	Originating Location	Enter the street address and city or town of the location from which the trip started. The name of a location or facility and the city or town in which it is located is also acceptable.
15	Destination Location	Enter the street address and city or town of the location at which the trip ended. The name of a location or facility and the city or town in which it is located is also acceptable.
16	Line	Each letter (A-J) refers to one of the 10 claim lines contained on the claim form. This letter will appear as the last character of the claim's transaction control number (TCN) listed on the remittance advice (RA).
17	Date of Service	Enter the date the service was provided in MMDDYY format.
18	Description of Service	Enter a brief description of the service provided.
19	Procedure Code-Modifier	Enter the service code that corresponds to the service provided. See Subchapter 6 of the applicable provider manual for list of payable and nonpayable service codes. For certain types of services, a two-character modifier must be entered after the service code to fully describe services. Add the applicable code to the end of the service code. See Subchapter 6 of your provider manual for the modifiers and descriptions, if applicable.

Item-by-Item Instructions for Claim Form No. 7 (cont.)

Item No.	Item Name	Description
20	No. of Miles	Leave this item blank when billing for the following services. • additional person on a one-way nonemergency ambulance trip; • additional person on a nonemergency round trip; • additional person on a chair-car round trip; • second attendant on a chair-car trip; • additional person on a one-way chair-car trip; and • other licensed carrier services. Otherwise, enter the total number of miles traveled while the member was a passenger. Use whole numbers only and round up to the nearest mile. If the provider charges a flat rate, enter the average number of miles reflected by that rate.
21	No. of Min. Waiting Time	Leave this item blank.
22	Place of Service	Enter the code from the list below that describes the origin and destination of the trip. For a round trip, enter the code that describes the first leg of the round trip. 11 – Nursing home to hospital for admission 12 – Nursing home to hospital emergency room or outpatient department 13 – Nursing home to doctor's office 14 – Nursing home to home 15 – Hospital to nursing home (discharge) 16 – Hospital to home (discharge) 17 – Home to hospital for admission 18 – Home to hospital emergency room or outpatient destination 19 – Home to doctor's office 20 – Nursing home to nursing home 21 – Hospital to hospital 22 – Doctor's office to home 23 – Doctor's office to hospital 24 – Home to freestanding clinic 99 – Other locations

Item-by-Item Instructions for Claim Form No. 7 (cont.)

Item No.	Item Name	Description
23	Usual Fee	Enter the provider's usual and customary fee for the service (amount charged to a person who is not a MassHealth member).
24	Other Paid Amount	Leave this item blank unless the member has other health insurance coverage. Do not enter previous MassHealth payments. Any amount entered in Item 24 will be deducted from the MassHealth payment.
25	Remarks	Leave this item blank.
26	Total Usual Fee	Leave this item blank.
27	Total Other Paid Amount	Leave this item blank.
28	Authorized Signature	The claim form must be signed by the provider or by an individual designated by the provider or hospital to certify that the information entered on the form is correct. Signatures other than handwritten signatures (for example, stamped, typewritten, or mechanically applied) are acceptable.
29	Billing Date	Enter in MMDDYY format the date on which the claim form is completed. This date cannot be prior to the last date of service on the form.
30	Adjustment/Resubmittal	If the claim is an adjustment or resubmittal, check theappropriate box. Use the resubmittal option for certain previously denied claims over 90 days. Do not make any entry in this item without completing Item 31. For additional information about correcting claims, consult Subchapter 5 of your MassHealth provider manual.
31	Former Transaction Control No. (TCN)	When an entry is required in this item, enter the 10-character transaction control number (TCN) assigned to the original claim. The TCN appears on the remittance advice that listed the original claim as paid or denied. This item is required if either of the boxes in Item 30 is checked. Refer to Part 7 of Subchapter 5 of your MassHealth provider manual before attempting to resubmit or adjust claims. Incorrect use of the TCN may result in denied claims.
32	For Office Use Only	Leave this item blank.